

B. *Advanced Metastatic* T1-4 N1-3 M1 $n=87$, 13% median prior PSA 93 ng/ml, post PSA 0.4 ng/ml. Presentation all symptomatic .RX LHRH 23%, Stilboesterol 17%, BTO 60%, COMP 20–34%, Hospital mortality 37%.

Conclusions: Prior to 2000 15.3% organ confined, T3/T4 32% and metastatic 52%. Improved facilities and skilled teams since 2004 led to organ confined PC 62% curable by RP, brachytherapy or EBRT with longer disease free survival but advanced disease pose challenges for disease control.

<http://dx.doi.org/10.1016/j.afju.2014.03.011>

Open prostatectomy for BPH in contemporary urological practice in Ibadan, Nigeria



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Introduction and objectives: Surgical excision remains the definitive treatment of benign prostatic hypertrophy and in this regard, open enucleation is the gold standard. Due to the morbidity associated with open surgery, less invasive methods of prostatic excision have been developed of which transurethral resection is the oldest and most widely used. However, minimally invasive procedures are best suited for small glands (80 g) whilst the glands of most black African men are large (100 g) making them unsuitable for enucleation via these methods. Also, the equipment and/or expertise for TURP are not widely available in sub-Saharan Africa. In our centre, open prostatectomy is the preferred option in ninety percent of patients requiring surgical treatment for BPH.

Methods: In this report, we describe our methods of open (retropubic) prostatectomy and emphasize modifications to the technique that have reduced morbidity and improved our results. We also compare the results of open prostatectomy with TURP in a select group of patients.

Conclusion: Retropubic prostatectomy is safe for treatment of large/very large prostate for which TURP would be difficult.

<http://dx.doi.org/10.1016/j.afju.2014.03.012>

Urethra

Catheter associated urethral strictures not an uncommon occurrence



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Objectives: To highlight the serious problem of urethral strictures developing as a result of catheterization either from traumatic catheterization or allergic reaction to catheters or infection.

To make recommendations to reduce the incidence of catheter associated urethral strictures.

Patients and methods: We reviewed our data base of patients coming for urethroplasties over a one year period at the Komfo Anokye Teaching Hospital from October 2012 to September 2013 to describe the stricture characteristics of those caused by catheters.

Results: Overall, 100 urethroplasties for urethral strictures were done during the study period. Of these, 15 were catheter associated. Most were located in the anterior urethra, most were multiple and of long lengths. Tissue transfer was employed in repair of most of these strictures.

Conclusions: Catheter associated urethral strictures are common, they are more complex, they require long surgery hours and their repairs are associated with more complications hence the need to prevent their occurrence.

<http://dx.doi.org/10.1016/j.afju.2014.03.013>

Management of complex urethral strictures in the Komfo Anokye Teaching Hospital, Kumasi, Ghana



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We present three cases of complex urethral strictures seen and managed at KATH to highlight the challenges faced with urethral stricture disease and the outcomes of management.

We discuss the case of a 46 year old man with pan urethral stricture following catheterization for Laminectomy, an 11 year old boy with a crush pelvic injury with membranous urethral stricture who had to undergo three urethroplasties before final relieve and finally the case of a 75 year old man with a 6 cm bulbar urethral stricture which was catheter associated who also had benign Prostatic hyperplasia and had to undergo urethroplasty as well as simple prostatectomy before final relieve.

<http://dx.doi.org/10.1016/j.afju.2014.03.014>